

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 30 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19654

State File No.

Registration District No. 818

Primary Registration District No. 1003

Registrar's No. 5583

1. PLACE OF DEATH:

(a) County...
(b) City or town... *St. Louis, Mo*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... *15 days*
(Specify whether
In this community... *0*
years, months or days)

3. (a) PRINT FULL NAME *ELVA ELLIOTT*

3. (b) If veteran, name war... *None*
3. (c) Social Security No. *None*

4. Sex *Female* 5. Color or race *White*
6. (a) Single, widowed, married, divorced *Married*

6. (b) Name of husband or wife... *Troy Elliott*
6. (c) Age of husband or wife if alive... *50* years

7. Birth date of deceased... *August 20 1898*
(Month) (Day) (Year)

8. AGE: Years Months Days
45 10 0
If less than one day
hr. min.

9. Birthplace *Douglas County Missouri*
(City, town, or county) (State or foreign country)

10. Usual occupation *Housewife*

11. Industry or business

12. Name *William Reece*
13. Birthplace *Unknown Unknown*
(City, town, or county) (State or foreign country)

14. Maiden name *Alicia Freeman*
15. Birthplace *Unknown Unknown*
(City, town, or county) (State or foreign country)

16. (a) Informant *Velma Elliott*
(b) Address *Festus, Missouri*

17. (a) *Burial* (b) Date thereof *6-23-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Vanzant, Missouri*

18. (a) Signature of funeral director *Albert H. Hoppe*

(b) Address *4700 Washington Blvd.*

19. (a) *JUN 20 1944* (b) *J. F. Breck*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Douglas*
(c) City or town *Vanzant*
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *June* day *20*
year *1944* hr. *10* minute *55 A.*M.

21. I hereby certify that I attended the deceased from *June 3 1944* to *June 10 1944*
that I last saw her alive on *June 20 1944*
and that death occurred on the date and hour stated above

Immediate cause of death *Lung Abscess* Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings: *abscesses of L.L.L.*
Of operations *exudate from bronchus of L.L.L.*
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature *M. C. Abney* (M. D. or other)
Address *BARNES HOSPITAL* Date signed *6/20/44*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.